FOR BHF USE

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026328

Facility Name: OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

Address: RR #4, 1320 WEST 9TH STREET (Number) MOUNT CARMEL (City) 62863 (Zip Code)

County: WABASH

Telephone Number: (618) 263-4337 **Fax #** (618) 262-7080

HFS ID Number: 371104153001

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(C)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: SCOTT COLE, ADMINISTRATOR **Telephone Number:** (618) 263-4337

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/2005 to 08/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SCOTT COLE

(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) JAMIE L. MCCORKLE, CPA

(Firm Name & Address) WILCOX, MCCORKLE & COMPANY, LTD. 328 MARKET STREET, MT. CARMEL, IL 62863

(Telephone) (618) 262-5446 Fax # (618) 262-8921

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/30/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,910	2,307	3,214	8,431	8
9	SNF/PED					9
10	ICF	12,956	7,376		20,332	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,866	9,683	3,214	28,763	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.56%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 3,214

Medicare Intermediary ADMINASTAR FEDERAL (INDIANAPOLIS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/06 Fiscal Year: 8/31/06

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 **Report Period Beginning:** 09/01/2005 **Ending:** 08/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,705	42,645	9,182	288,532		288,532		288,532			1
2	Food Purchase		190,466		190,466		190,466	(4,926)	185,540			2
3	Housekeeping	130,821	45,166		175,987		175,987		175,987			3
4	Laundry	21,131	4,934	12,745	38,810		38,810		38,810			4
5	Heat and Other Utilities			132,883	132,883		132,883		132,883			5
6	Maintenance	50,480	27,638	81,283	159,401		159,401		159,401			6
7	Other (specify):*											7
8	**TOTAL General Services**	439,137	310,849	236,093	986,079		986,079	(4,926)	981,153			8
	B. Health Care and Programs											
9	Medical Director			700	700		700		700			9
10	Nursing and Medical Records	1,134,842	129,682	57,911	1,322,435		1,322,435		1,322,435			10
10a	Therapy		3,668	234,709	238,377		238,377		238,377			10a
11	Activities	65,140	2,291	430	67,861		67,861		67,861			11
12	Social Services	30,786		3,486	34,272		34,272		34,272			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,230,768	135,641	297,236	1,663,645		1,663,645		1,663,645			16
	C. General Administration											
17	Administrative	113,251			113,251		113,251		113,251			17
18	Directors Fees			3,701	3,701		3,701		3,701			18
19	Professional Services			38,439	38,439		38,439		38,439			19
20	Dues, Fees, Subscriptions & Promotions			30,431	30,431		30,431		30,431			20
21	Clerical & General Office Expenses	100,770	23,562	128,484	252,816		252,816		252,816			21
22	Employee Benefits & Payroll Taxes			406,056	406,056		406,056		406,056			22
23	Inservice Training & Education			3,458	3,458		3,458		3,458			23
24	Travel and Seminar			34,058	34,058		34,058		34,058			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,214	22,214		22,214		22,214			26
27	Other (specify):* CABLE TV			4,577	4,577		4,577	(4,577)				27
28	**TOTAL General Administration**	214,021	23,562	671,418	909,001		909,001	(4,577)	904,424			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,883,926	470,052	1,204,747	3,558,725		3,558,725	(9,503)	3,549,222			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL #0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			243,796	243,796		243,796		243,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			260,337	260,337		260,337	(67)	260,270			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,566	7,566		7,566		7,566			35
36	Other (specify):*											36
37	**TOTAL Ownership**			511,699	511,699		511,699	(67)	511,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			49,275	49,275		49,275		49,275			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,883,926	470,052	1,765,721	4,119,699		4,119,699	(9,570)	4,110,129			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	4,926	2		4
5	Telephone, TV & Radio in Resident Rooms	4,577	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	67	25		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 9,570		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 9,570		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328

Report Period Beginning: 09/01/2005

Ending: 08/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 **Report Period Beginning:** 09/01/2005 **Ending:** 08/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	4,926	0	0	0	0	0	0	0	0	0	0	4,926	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,926	0	0	0	0	0	0	0	0	0	0	4,926	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	67	0	0	0	0	0	0	0	0	0	0	67	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	4,577	0	0	0	0	0	0	0	0	0	0	4,577	27
28	**TOTAL General Administration**	4,644	0	0	0	0	0	0	0	0	0	0	4,644	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	9,570	0	0	0	0	0	0	0	0	0	0	9,570	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII **#** 0026328 **Report Period Beginning:** 09/01/2005 **Ending:** 08/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,570	0	0	0	0	0	0	0	0	0	0	9,570	45

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTI# 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE	NONE	N/A		OAKVIEW VILLA	MT. CARMEL	SUPPORTIVE LIVI

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAl # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 09/01/2005 Ending: 8/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GERSHMAN MORTGAGE		X	MORTGAGE	$44,690.00	4/31/04	$ 6,098,158	$ 5,961,937	04/13/44	5.8000	$ 247,520	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANK		X	LINE OF CREDIT	VARIOUS	12/05/05	250,000	82,987	12/05/06	7.7500	12,817	6
7	GEN BAPTIST NH BOARD	X		LOAN	VARIOUS	01/2006	291,498	291,498	01/2007			7
8												8
9	TOTAL Facility Related				$44,690.00		$ 6,639,656	$ 6,336,422			$ 260,337	9
	B. Non-Facility Related*											
10	INTEREST INCOME										(67)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (67)	14
15	TOTALS (line 9+line14)						$ 6,639,656	$ 6,336,422			$ 260,270	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION C] # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2001		8
	2002		9
	2003		10
	2004		11
	2005		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILI COUNTY WABASH

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTEI # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Concrete/Sandstone Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENT USE	352,863	1981	$ 89,216	1
2	RESIDENT USE	270,630	1994	60,000	2
3	TOTALS	623,493		$ 149,216	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CEN # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1981	1982	$ 775,625	$ 25,854	30	$ 25,854	$	$ 646,354	4
5				2005	3,461,501	87,083	40	87,083		93,749	5
6				2006	1,109,737	22,314	40	22,314		22,314	6
7											7
8											8
	Improvement Type**										
9	ROOF			1982	3,837		7			3,837	9
10	BUILDING IMPROVEMENTS			1994	2,914		10			2,914	10
11	ROOF			1996	68,042	2,268	30	2,268		22,869	11
12	ROOF			1996	11,450	382	30	382		3,753	12
13	ELECTRICAL- NEW WIRING			1997	23,632	945	25	945		8,350	13
14	DRYWALL			1997	21,125	1,408	15	1,408		12,205	14
15	CARPET			1998	7,927		7			7,927	15
16	SIGN			1998	2,000	133	15	133		1,089	16
17	WALL PAPER			1998	2,435		7			2,435	17
18	PLASTIC COAT: ROOF-WING 5			1998	12,500	417	30	417		3,542	18
19	12 LAVATORY FAUCETS			1998	4,470	298	15	298		2,583	19
20	9 OVERHEAD LIGHTS			1998	921	61	15	61		532	20
21	EXIT SIGN			1998	449	30	15	30		260	21
22	OTHER MG-INC PLUMBING			1998	9,003	600	15	600		5,102	22
23	CARPET, CURTAINS, BLINDS			1998	11,249	1,125	10	1,125		8,905	23
24	CARPET, CURTAINS, BLINDS			1998	19,656	1,966	10	1,966		15,561	24
25	FUEL TANK			1999	8,935	596	15	596		4,368	25
26	WALL PAPER			1999	4,135	276	15	276		2,045	26
27	KITCHEN			2000	4,230	423	10	423		2,715	27
28	BRITTINGTON AIR & WATER			2000	1,992	285	7	285		1,731	28
29	BUILDING HANDRAILS			2000	3,818	545	7	545		3,500	29
30	NORTH-SIDE HEATERS			2001	6,090	870	7	870		4,857	30
31	WATER HEATERS			2001	15,196	2,171	7	2,171		10,854	31
32	TILE - WING 7			2000	3,753	536	7	536		3,041	32
33	FIRE DOORS			2000	4,861	486	10	486		2,795	33
34	LAND IMPROVEMENTS			1982	14,363		10			14,363	34
35	GAZEBO			1997	3,495	349	10	349		3,116	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CEN # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT REPAVEMENT	1997	$ 12,677	$ 1,268	10	$ 1,268	$	$ 11,304	37
38	LANDSCAPING	1997	8,836	589	15	589		5,106	38
39	DITCH WORK	1997	700	47	15	47		416	39
40	RESEAL PARKING LOT	1999	3,336		5			3,336	40
41	LANDSCAPING	1999	976	65	15	65		483	41
42	LAND IMPROVEMENTS	2000	647	43	15	43		277	42
43	LAND IMPROVEMENTS	2001	380	25	15	25		141	43
44	LAND IMPROVEMENTS	2005	316,403	21,094	15	21,094		22,851	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,963,296	$ 174,552		$ 174,552	$	$ 961,580	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RE # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 518,121	$ 64,923	$ 64,923	$	5-7	$ 246,246	71
72	Current Year Purchases	26,368	2,361	2,361		7	2,361	72
73	Fully Depreciated Assets	111,963					111,963	73
74								74
75	TOTALS	$ 656,452	$ 67,284	$ 67,284	$		$ 360,570	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY USE	1986 MAZDA TRUCK	1992	$ 4,474	$	$	$	5	$ 4,474	76
77	FACILITY USE	1996 CHEVY VAN	1995	23,548				5	23,548	77
78	FACILITY USE	1998 FORD PICKUP	2002	9,799	1,960	1,960		5	8,493	78
79										79
80	TOTALS			$ 37,821	$ 1,960	$ 1,960	$		$ 36,515	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,806,785	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,796	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,796	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,358,665	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION (# 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	20-3	hrs	$		$ 115,008	$		$ 115,008	1
2	Licensed Speech and Language Development Therapist	20-3	hrs			19,511			19,511	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	20-2 & 20-3	hrs			100,190	3,668		103,858	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 234,709	$ 3,668		$ 238,377	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII# 145376 **Report Period Beginning:** 9/1/2005 **Ending:** 8/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2006 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 258,245	$ 286,714	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	294,735	438,057	3
4	Supply Inventory (priced at)	32,001	32,001	4
5	Short-Term Investments			5
6	Prepaid Insurance	37,665	43,288	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 622,646	$ 800,060	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216	179,216	13
14	Buildings, at Historical Cost	5,963,296	7,908,439	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	694,274	803,145	16
17	Accumulated Depreciation (book methods)	(1,358,666)	(1,466,167)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,448,120	$ 7,424,633	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,070,766	$ 8,224,693	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 182,033	$ 182,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	431,603	431,603	29
30	Accrued Salaries Payable	72,049	72,049	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,871	69,871	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	40,055	40,055	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		8,370	8,370	36
37		3,163	3,163	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 807,144	$ 807,425	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,904,819	8,230,145	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,904,819	$ 8,230,145	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,711,963	$ 9,037,570	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (641,197)	$ (812,877)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,070,766	$ 8,224,693	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATIO # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (199,807)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (199,807)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(441,390)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (441,390)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (641,197)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & F # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,668,290	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,668,290	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,384	13
14	Non-Patient Meals	7,568	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,952	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 67	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,678,309	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	986,079	31
32	Health Care	1,663,645	32
33	General Administration	909,001	33
	B. Capital Expense		
34	Ownership	511,699	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,119,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	(441,390)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (441,390)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,200	$ 47,223	$ 21.47	1
2	Assistant Director of Nursing	2,120	2,184	41,018	18.78	2
3	Registered Nurses	8,550	8,806	141,351	16.05	3
4	Licensed Practical Nurses	27,772	28,092	369,421	13.15	4
5	CNAs & Orderlies	70,641	73,158	523,080	7.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,060	2,100	32,167	15.32	9
10	Activity Assistants	4,160	4,240	32,973	7.78	10
11	Social Service Workers	2,480	2,560	30,786	12.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,120	4,200	28,805	6.86	14
15	Cook Helpers/Assistants	31,500	31,740	207,900	6.55	15
16	Dishwashers					16
17	Maintenance Workers	6,980	7,060	50,480	7.15	17
18	Housekeepers	19,853	19,973	130,821	6.55	18
19	Laundry	3,040	3,120	21,131	6.77	19
20	Administrator	2,220	2,300	72,500	31.52	20
21	Assistant Administrator	2,000	2,080	40,751	19.59	21
22	Other Administrative	1,440	1,520	12,749	8.39	22
23	Office Manager					23
24	Clerical	7,940	8,060	100,770	12.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,996	203,393	$ 1,883,926 *	$ 9.26	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,182	1:3	35
36	Medical Director		700	9:3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,641	10:3	39
40	Physical Therapy Consultant		100,190	10a:3	40
41	Occupational Therapy Consultant		115,008	10a:3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		19,511	10a:3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 247,232		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	360	$ 23,335	10:3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	360	$ 23,335		53

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RE # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SCOTT COLE	ADMINISTRATOR	N/A	$ 72,500
TRACY COLE	ASST ADMIN	N/A	40,751
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 113,251

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
WILCOX, MCCORKLE & CO	AUDITING	$ 7,950
WILCOX, MCCORKLE & CO	HUD CONSTRUCTION AUDIT	4,500
WILCOX, MCCORKLE & CO	CONSULTING	7,250
WILCOX, MCCORKLE & CO	DPA COST REPORT	4,000
LASHLY & BAER	LEGAL FEES	14,409
OTHER MISCELLANEOUS		330
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 38,439

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,566
Unemployment Compensation Insurance	29,758
FICA Taxes	144,120
Employee Health Insurance	147,804
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	808
TOTAL (agree to Schedule V, line 22, col.8)	$ 406,056

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,818
Advertising: Employee Recruitment	18,885
Health Care Worker Background Check	3,525
(Indicate # of checks performed)	
VARIOUS DUES & FEES	6,203
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,431

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	34,058
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,058

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION # 0026328 Report Period Beginning: 09/01/2005 Ending: 08/31/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORK OF ILLINOIS**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10:2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **49,275**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **WILCOX, MCCORKLE & COMPANY, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.